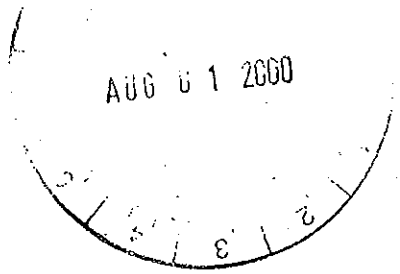
IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION



GAYNELL GRIER, et al., individually and on behalf of others similarly situated,	)	
Plaintiffs,	)	
v.	)	Civil Action No. 79-3107
	)	Judge John T. Nixon
FREDIA WADLEY, Commissioner, Tennessee Department of Health; et al.,	)	
Defendants	)	
and	)	
TENNESSEE ASSOCIATION OF HEALTH MAINTENANCE ORGANIZATIONS, et al.,	)	
Defendants-Intervenors	)	

ORDER

Upon motion of the plaintiffs and in accordance with the June 26, 2000, order of remand by the Court of Appeals, the Court finds that the Revised Consent Decree Governing TennCare Appeals [Docket entry 492; October 26, 1999] should be modified to correct technical errors, clarify its terms and allow more time for its full implementation. This order therefore supersedes that Decree. The Court approves the interpretations and guides to implementation that are attached as Exhibit A to this order, and that were distributed by the state defendants to their managed care contractors at a training on February 28, 2000 regarding implementation.

On March 11, 1999, the plaintiffs filed a motion to hold the defendants in contempt of court for violation of the second consent decree [Docket entry 278] as modified by the Agreed Order entered on August 27, 1996 [Docket Entry No. 387]. The defendants, by entering into the Revised Consent Decree Governing TennCare Appeals did not admit liability or noncompliance with the terms of this Court's previous orders, nor do they do so now.

The Court hereby incorporates and fully reaffirms its memorandum of May 16, 1996 (Docket Entry 376), as modified by the Court of Appeals, and the Order of August 27, 1996 (Docket Entry 387). To ensure compliance with that Order and with the federal regulations which it embodies, and to clarify its terms, the court, by agreement of the original parties, hereby permanently enjoins the state defendants as follows. The original parties intend to adequately protect the due process rights of plaintiff class members in the context of managed care. Toward that end, the original parties have agreed on the provisions in this order as one means by which to achieve that result. The original parties recognize that, in doing so, they have, with respect to certain provisions, expanded or otherwise adapted the protections afforded by 42 C.F.R. Part 431, Subpart E, which was promulgated for Medicaid fee-for-service systems.

A. Applicability of Terms

This order and previous orders incorporated by reference shall apply fully to the state defendants, their agents, servants, employees, and attorneys, and those persons in active concert or participation with them, including any private or public entity that administers Medicaid-funded health benefits. These orders shall apply specifically, but not be limited to, the state defendants and their managed care contractors (MCC) which operate provider networks, whether designated as managed care organizations (MCOs), behavioral health organizations (BHOs), pharmacy benefit managers (PBMs), dental benefit managers or state government agencies.

B. Definitions.

1. References to the "defendants" in this action shall mean the named state defendants.

2. The term "medical assistance" means health care, services, and supplies furnished to an eligible individual and funded in whole or in part under Title XIX of the Social Security Act ("The Medicaid Act"), 42 U.S.C. §§1396 *et seq*. Medical assistance includes the payment of the cost of care, services, drugs and supplies. Such care, services, drugs and supplies shall include services of qualified providers, as defined herein.

3. References to "TennCare benefits" or "TennCare services" include any medical assistance that is administered by the state defendants or their contractors and which is funded wholly or in part with federal funds under the Medicaid Act, but excluding:

   i. Medical assistance that can be appealed through an appeal of a pre-admission evaluation (PAE) determination; and

   ii. Medicare cost sharing services that do not involve utilization review by the defendants or their contractors.

4. References to "beneficiaries", "enrollees", "recipients" or "patients" include any individuals eligible for, and enrolled in, Tennessee's medical assistance program administered under the terms of the Medicaid Act or any federal Medicaid waiver, and amendments thereto, granted by the Secretary of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act. As concerns an MCC's compliance, the term only applies to those for whom the MCC has received at least one day's prior written or electronic notice from the TennCare Bureau of the individuals' assignment to the MCC.

5. References to "adverse action" affecting TennCare benefits include, but are not limited to, delays, denials, reductions, suspensions or terminations of TennCare benefits, as well as to any other acts or omissions of the defendants which impair the quality, timeliness or availability of such benefits.

Example: A person seeks dental care for her child, who is complaining of a painful tooth. The MCO refers her to one dental office where she cannot obtain an appointment for 6 weeks, and to a second provider that is 40 miles away. The beneficiary can pursue an appeal to challenge the delay in receiving TennCare-covered services regardless of the reason for the delay.

Example: An MCO seeks to "lock-in" a beneficiary to a particular pharmacy, so that the person can only obtain prescription medications from that specific provider. The MCO's proposed action may limit or delay the beneficiary's access to pharmacy services, and must therefore be treated as an adverse action affecting TennCare benefits. The beneficiary is entitled to prior notice and appeal rights as provided in this order.

6. References to "delay" include, but are not limited to:

   a. Any delay in receipt of TennCare services, and no specific waiting period may be required before the beneficiary can appeal

   b. An MCC's failure to provide timely prior authorization of a TennCare service is a delay. In no event shall a prior authorization decision be deemed timely unless it is granted within 21 calendar days of a request for such authorization, and a shorter period is required if a more prompt response is medically necessary in light of the beneficiary's condition and the urgency of his need, as defined by a prudent lay person.

7. References to "reduction", "suspension" or "termination" of TennCare services include acts or omissions on the part of the state defendants or others acting on their behalf which result in the interruption of a course of necessary clinical treatment for a continuing spell of illness or medical condition. For purposes of compliance with this order and the regulations

which it embodies, the state defendants acknowledge that their managed care contractors are responsible for the management and provision of medically necessary covered services throughout a beneficiary's illness or need for such services, and across the continuum of covered services, including, but not limited to behavioral health services and appropriate transition plans specified in the applicable TennCare contract. Therefore, the fact that a beneficiary's medical condition requires a change in the site or type of TennCare service does not lessen the contractor's obligation to provide covered treatment on a continuous and ongoing basis as medically necessary.

8. A "decision in favor of a beneficiary [or enrollee]" refers, in the case of a decision by an administrative law judge (ALJ), to the initial decision on the merits of the appeal, and shall be treated by the defendants as binding for purposes of this order.

9. The term "provider" means a health care provider eligible by professional qualifications to participate in TennCare, and who is acting within her scope of practice.

10. The term "treating physician [or clinician]" refers to a health care provider who has provided diagnostic or treatment services for a beneficiary (whether or not those services were covered by TennCare), for purposes of treating, or supporting the treatment of, a known or suspected medical condition. The term excludes providers who have evaluated a beneficiary's medical condition primarily or exclusively for the purpose of supporting or participating in a decision regarding TennCare coverage.

11. The term "readable" means that a notice or other written communication requires no more than a sixth grade level of reading proficiency to understand, as measured by the Fogg index or other recognized readability instrument.

12. References to "continuation of services [or benefits] pending review [or appeal]" and references to "reinstatement of services [or benefits] pending review [or appeal]" include either:

a. Those services currently or, (in the case of reinstatement) most recently, provided to a TennCare beneficiary; or

b. Those services being provided to an enrollee in an inpatient psychiatric facility or residential treatment facility where the discharge plan has not been accepted by the enrollee or appropriate step-down services are not available; or

c. Those services being provided to treat a patient's chronic condition across a continuum of services when the next appropriate level of covered services is not available.

Example: A TennCare enrollee is hospitalized after a stroke and, upon discharge from the hospital will continue to require physical therapy from a home health agency. If timely home health services are not in place at the time of discharge, the patient may obtain continuation of hospital care pending appeal, or until the home health services are available to ensure continuation of care upon discharge.

d. Those services prescribed by the enrollee's provider on an open-ended basis or with no specific ending date where the MCC has not reissued prior authorization; or

e. A different level of covered services, offered by the MCC and accepted by the enrollee, for the same illness or medical condition for which the disputed service has previously been provided.

Example: A TennCare beneficiary's treatment in an inpatient psychiatric hospital is being, or has been reduced, terminated or suspended, but he continues to need active care for his mental illness. Upon timely appeal of the adverse action affecting his inpatient care, the beneficiary may elect to either continue inpatient services or to receive other appropriate covered TennCare services, such as residential treatment facility (RTF) services. If the beneficiary is eligible for continuation of services and is offered and elects to receive the lower level of care pending appeal, the BHO must arrange for a transfer from hospital to RTF in such a manner that there is no break in

the beneficiary's treatment. If the beneficiary is eligible for reinstatement of services and is offered and elects to receive the lower level of care pending appeal, the BHO must provide those services within 24 hours of receipt of the beneficiary's request.

13. For purposes of this order, receipt of mailed notices is presumed to occur within 5 days of mailing.

14. Time-sensitive care is care which requires a prompt medical response in light of the beneficiary's condition and the urgency of her need, as defined by a prudent lay person; provided, however, that a case may be treated as non-time-sensitive upon the written certification of the beneficiary's treating physician.

15. As referred to in this order in the context of TennCare pharmacy services, a provider with prescribing authority is a health care professional authorized by law or regulation to order prescription medications for her patients, and who:

    a. participates in the provider network of the MCC in which the beneficiary is enrolled; or

    b. has received a referral of the beneficiary, approved by the MCC, authorizing her to treat the beneficiary; or

    c. in the case of a TennCare beneficiary who is also enrolled in Medicare, is authorized to treat Medicare patients.

C. Prohibitions and Duties

1. ***Notice Contents***. Whenever the federal regulations or this Order require that a TennCare beneficiary receive notice of an adverse action affecting medical assistance, the notices shall contain the following elements, written in concise, readable terms.

    a. The type and amount of TennCare services at issue and the identity of the individual, if any, who prescribed the services;

b. A statement of reasons for the proposed action. The statement of reasons shall include the specific facts, personal to the beneficiary, which support the proposed action and sources from which such facts are derived. If the proposed action turns on a determination of medical necessity or other clinical decision, the statement of reasons shall:

i. Identify by name those clinicians who were consulted in reaching the decision at issue;

ii. Identify specifically those medical records upon which those clinicians relied in reaching their decision;

iii. Specify what part(s) of the criteria for medical necessity or coverage was not met; and

iv. Inform the enrollee about the opportunity to contest the decision, including the right to an expedited appeal in the case of time-sensitive care and a right to reinstated or ongoing medical services pending appeal.

Attached as part of Collective Exhibit B to this order is a sample notice that shall be used by the defendants as templates for the notices they issue.

c. If the beneficiary has an ongoing illness or condition requiring medical care and the MCC or its network provider is under a duty to provide a discharge plan or otherwise arrange for the continuation of treatment following the proposed adverse action, the notice must be given and shall include a readable explanation of the discharge plan, if any, and a description of the specific arrangements in place to provide for the beneficiary's continuing care.

Example: A TennCare beneficiary is receiving psychiatric treatment in a hospital and the BHO refuses to certify, or authorize, a continuation of his hospitalization. The

beneficiary is still severely mentally ill, however, and the BHO is responsible for his continuing care. The notice of termination of inpatient hospital services must include information regarding the availability of case management services and must describe the other TennCare services that will be in place at the time of discharge. If those services are not initiated prior to discharge from the psychiatric hospital, the notice shall specify the time of the first appointment at which those services will be provided.

Attached as part of Collective Exhibit B to this order is a sample notice that satisfies the requirements of this provision, and that shall be used by the defendants as a template for the notices they issue.

d. The required reference to the legal or policy basis for a proposed adverse action shall include a plain and concise statement of the applicable law, federal waiver provision or TennCare contract, as well as its official citation with a brief statement of the reasons for the adverse action based upon the individual enrollee's circumstances. The defendants and others acting on their behalf may not cite or rely upon policies that are inconsistent with federal law, the TennCare waiver, properly promulgated rules or contract provisions.

e. If the service at issue is a prescription drug, a written notice shall be provided by the pharmacy to inform the beneficiary of the circumstances under which the beneficiary may obtain a two week supply of the prescribed medicine and how to do so, as well as the beneficiary's right to appeal the denial or termination of the medication and how to do so. Attached as part of Collective Exhibit B to this order is a sample notice that satisfies the requirements of this provision, and that shall be used by the defendants as a template for the notices they issue.

f. In the event that a beneficiary appeals a denial or termination of a pharmacy benefit and the appeal is not resolved to the beneficiary's satisfaction within 10 days from

the date of appeal, the MCC shall issue a notice containing the information prescribed in subparagraphs (a) and (b) of this section.

g. The defendants and others acting on their behalf shall be bound by their own notices, and may not rely upon any reasons or legal authorities other than those which they include in their written notices to a TennCare beneficiary. In the event that a beneficiary appeals an adverse action, the reviewing authority shall consider only the factual reasons and legal authorities cited in the original notice to the beneficiary, except that additional evidence beneficial to the enrollee may be considered on appeal.

h. If the MCC's reasons or legal authorities are not sufficient to support the proposed action, the proposed action must be overruled and the disputed service must be provided. Nothing herein shall preclude the issuance of a new notice that may provide the predicate for subsequent adverse action, but such new notice shall not cure the deficiencies of the original notice.

2. ***When notice is required.***

a. The defendants and their contractors shall provide notice in the circumstances, and within the time frames required by 42 C.F.R. §§431.210-214, except as modified and adapted herein below.[1]

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1. The parties intend that, in order to adequately protect the due process rights of plaintiff class members in the context of managed care, subparagraph (C)(2)(d) expands the protections afforded by 42 C.F.R. § 431.213(f), by modifying the provision allowing same day notice in certain cases where the beneficiary's clinician initiates the proposed action. As modified by this order, same day notice will not suffice in the circumstances specified in subparagraph (C)(2)(d); notice must be received by the beneficiary at least two business days in advance of the proposed action. In cases involving inpatient hospital treatment, where the beneficiary's treating provider does not initiate the reduction, suspension or termination of such services, the ten day notice required by 42 C.F.R. § 431.211 may be shortened to two business days, if the defendants or their contractors comply with the other safeguards afforded by this order.

b. Whenever an MCC has reason to expect that covered medical assistance for a TennCare beneficiary will be delayed beyond the time limits prescribed by the TennCare contract or the terms and conditions of the TennCare waiver, it shall immediately issue notice to the beneficiary. Among the MCC actions which can reasonably be anticipated to delay or disrupt access to medical assistance are the following:

i. Changes of primary care provider;

ii. Pharmacy "lock-in";

iii. Decisions affecting the designation of a person as severely and persistently mentally ill (SPMI) or severely emotionally disturbed (SED);

iv. Termination of a provider's contract, by either party to the contract;

v. Inability to provide an adequate provider network.

Attached as part of Collective Exhibit B to this order is a sample notice that satisfies the requirements of this provision, and that shall be used by the defendants as a template for the notices they issue.

c. When a TennCare enrollee has been prescribed a covered service on an ongoing basis or with no specific ending date and the service is subject to a prior authorization requirement, the MCC shall provide notice containing the information required by this order. The notice must be provided no more than 40 days, or less than 30 days, prior to the expiration of prior authorization for the service. In the event that the period of authorization is less than 30 days, the notice shall be issued upon authorization. Attached as part of Collective Exhibit B to this order is a sample notice that satisfies the requirements of this provision, and that shall be used by the defendants as a template for the notices they issue.

d. The MCC shall provide at least two (2) business days' advance notice[2] of any provider-initiated reduction, termination or suspension of:

i. Any behavioral health service for a severely and persistently mentally ill (SPMI) adult enrollee or severely emotionally disturbed (SED) child;

ii. Any inpatient psychiatric or residential service;

iii. Any service being provided to treat a patient's chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available; or

iv. Home health services.

The notice shall contain the information required by subsection C(1)(a) and (b) of this order, as well as a readable summary of the discharge plan or transitional care plan for the enrollee's care following the proposed action. Attached as part of Collective Exhibit B to this order is a sample notice that satisfies the requirements of this provision, and that shall be used by the defendants as a template for the notices they issue.

e. The defendants shall provide annual notice to TennCare enrollees of the notice and appeal rights established by this order, including enrollees' recourse when billed by a provider for TennCare covered services. Attached as part of Collective Exhibit B to this order is a sample notice that satisfies the requirements of this provision.

f. The Tennessee Department of Children's Services (DCS) must provide notice of any delay in providing a service that is administered by DCS. Such delay is immediately appealable

2. The parties agree that, after this order has been in effect for at least six months, the defendants may apply to the Court to shorten the period of advance notice required by this subsection from two business days to two calendar days, upon a showing that the state and its contractors have established procedures that, in the context of a shortened notice period, ensure equivalent due process protections for beneficiaries. The plaintiffs may apply to the Court to lengthen the advance notice period to 10 days, as provided by 42 C.F.R. §431.211, for reductions, terminations or suspensions of inpatient hospital care initiated by the defendants or MCCs.

on the child's behalf. The defendants cannot require that the delay last a particular length of time before issuing the notice or processing an appeal.

Example: A child enters state custody and is identified as having a need for TennCare-covered therapeutic foster care for treatment of a severe emotional disturbance. DCS temporarily places the child in a standard foster home while waiting for a therapeutic foster home placement to become available. DCS must provide notice as provided in this order that the delay in providing the prescribed service is immediately appealable on the child's behalf.

Attached as part of Collective Exhibit B to this order is a sample notice that satisfies the requirements of this provision, and that shall be used by the defendants as a template for the notices they issue.

g. No adverse action affecting TennCare benefits shall be effective unless the defendants and/or others acting on their behalf have complied with the notice requirements of the federal regulations, 42 C.F.R. § 431.210 - 214, as enhanced herein. Defendants shall not withhold, or permit others acting on their behalf to withhold, any TennCare services in violation of this requirement. As provided below, the defendant state officials shall actively monitor compliance by their contractors and, in the event of a violation, shall impose the regulatory and contractual sanctions available to the defendants to enforce compliance with the TennCare contracts and applicable law.

3. ***Corrective Action.***

a. Whenever it comes to the attention of the defendants that a TennCare covered service will be or has been delayed, denied, reduced, suspended or terminated in violation of any of the notice requirements of this order, they shall immediately provide, or require their contractor to provide that service in the quantity and for the duration prescribed, subject to the MCC's right to reduce or terminate the service in accordance with the procedures required by this order.

b. In the event that the beneficiary lacks a prescription for a covered TennCare service, the defendants shall:

i. Immediately afford the beneficiary access, at the earliest time practicable, to a qualified provider to determine whether the service should be prescribed; and

ii. Inform said provider that the service will be authorized if prescribed.

Entitlement to said service will not be controlled by the contractor's utilization review process.

c. In the case of a delay of access to a physician to secure the requested medical assistance, the defendants shall provide such access as soon as practicable. The TennCare beneficiary shall be entitled to continue to receive such service until such time as the contractor takes those actions required by federal regulations and this order as a prerequisite to taking any adverse action affecting TennCare benefits.

4. ***Individualized decisions required.*** The defendants shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or *de facto*, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare beneficiary and his or her medical history.

Example: A BHO adopts a policy that routinely permits approval of only 5 therapy sessions for a given diagnosis, and that requires TennCare beneficiaries to appeal in order to receive a larger amount prescribed by their clinician. Upon appeal, the beneficiary is entitled to the full number of therapy sessions ordered by the clinician. State officials must prohibit the contractor from continuing to impose an arbitrary limit and must impose sanctions on the BHO for violating this provision.

Example: A TennCare beneficiary with a chronic illness is prescribed home health services 8 hours per day, 7 days per week, on an open-ended basis. The beneficiary's MCO approves the care for only 30 days, based upon an individualized determination that the beneficiary is unlikely to require care beyond that period. Because the decision is not the result of applying an arbitrary limit of general application, the action is not prohibited by this order. However, it does constitute an adverse action affecting benefits. The defendants

or their contractor must treat the time limit on the authorization as a reduction or termination of the service, and must comply with all applicable terms of this order, including continuation of services pending appeal.

Example: A severely and persistently mentally ill beneficiary is on a long term psychotropic medication. The PBM requires the authorization for the medication to be renewed periodically. The expiration of the prescription, or the limit on its renewal, is not the result of a clinical judgment of the prescribing provider which is based upon the individual patient's medical condition.

The notice must be provided no more than 40 days, or less than 30 days, prior to the expiration of prior authorization for the service. In the event that the period of authorization is less than 30 days, the notice shall be issued upon authorization.

5. ***Provider-initiated reductions, suspensions or terminations for certain enrollees.***

a. The defendants shall ensure that before a provider-initiated reduction, suspension or termination occurs which affects services described in subparagraph 2(d) of this section, the TennCare beneficiary receives at least two (2) business days' prior written notice as provided in that subparagraph.[3]

b. If, prior to the actual termination, reduction or suspension of services covered by subparagraph (2)(d), the beneficiary makes a request for continuation of those services pending appeal, the defendants shall arrange for the continuation of those services until the beneficiary is afforded access to a written second medical opinion from a qualified provider who participates in the MCC's network. Services shall continue thereafter pending appeal only if and to the extent prescribed by that provider. Provided, however, that the services at issue may be immediately reduced, terminated or suspended if medically contraindicated, as determined in accordance with subsection (C)(18) of this order.

c. If, within 10 days of receipt of the notice required by subparagraph (C)(2)(d), but after the actual reduction, termination or suspension of services, the beneficiary requests that

the services be reinstated pending appeal, the defendants shall, within two business days, afford the beneficiary access to a written second medical opinion from a qualified provider who participates in the MCC's network. The services shall be immediately reinstated pending appeal, if and to the extent prescribed by that provider.

6. ***Record on review.*** Whenever the state defendants receive an appeal from a TennCare beneficiary regarding an adverse action affecting TennCare services, the defendants shall be responsible for obtaining from their contractor any and all records or documents pertaining to the contractor's decision to take the contested action. The defendants shall be responsible for correcting any violation of this order that is evident from a review of those records. Specifically, if it appears from the contractor's records that the adverse action is based on grounds other than those cited in the notice to the TennCare beneficiary, the defendants shall overrule the contractor and take such further corrective action as is reasonably necessary to ensure future compliance.

7. ***Decisions to be supported by substantial and material evidence***. In any appeal of an adverse action affecting TennCare benefits, throughout all stages of such appeal, the defendants shall ensure that decisions are based upon substantial and material evidence. In cases involving clinical judgments, this requirement specifically means that:

   a. Appeal decisions must be supported by medical evidence, and it is the defendants' responsibility to elicit from beneficiaries and their treating providers all pertinent medical records that support an appeal; and

   b. The decisions or opinions of a TennCare beneficiary's treating physician or other prescribing clinician shall not be overruled by either the MCC initially or the state

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3. This requirement is subject to the provision contained in note 2, above.

defendants upon review, unless there is substantial and material medical evidence, documented in the beneficiary's medical records, to justify such action. Reliance upon insurance industry guidelines or utilization control criteria of general application, without consideration of the individual enrollee's medical history, does not satisfy this requirement and cannot be relied upon to support an adverse action affecting TennCare services.

8. ***Continuation or Reinstatement of TennCare benefits***. The defendants and others acting on their behalf shall ensure that, pursuant to 42 C.F.R. §§ 431.230-231 as adapted by this order, plaintiff class members receive continuation or reinstatement of services, as defined in this order, pending appeal when they submit a timely appeal and request for such services.[4] The defendants and others acting on their behalf are prohibited from denials of continuation or reinstatement of services to which they are entitled under this order, including, but not limited to, denials resulting from:

   a. An MCC's failure to inform beneficiaries of the availability of such continued services;

   b. An MCC's failure to reimburse providers for delivering services pending appeal; or

   c. An MCC's failure to provide such services when timely requested.

9. ***Preservation of appeal and hearing rights***. The defendants and others acting on their behalf are enjoined to provide the plaintiff class members those appeal rights that are prescribed by 42 C.F.R. Part 431, Subpart E and T.C.A. §§ 4-5-301 et seq.

4. The parties intend that, in order to adequately protect the due process rights of plaintiff class members in the context of managed care, this provision adapts the protections afforded by 42 C.F.R. § 431.230-231, by modifying the provision allowing continuation of services pending appeal. Cf. subsections (B)(12) and (C)(5), above.

a. The defendants shall maintain a central registry for all appeals by enrollees as described herein. The establishment of a central registry for BHO services may be delegated to the Tennessee Department of Mental Health and Mental Retardation. The purpose of these registries is merely clerical. The appeal will be entered into a system for tracking and monitoring and will be referred to the appropriate MCC.

b. The defendants shall ensure that written requests for appeals made at a county Department of Human Services or Health Department office shall be stamped, and immediately forwarded to the defendants for processing and entry in the central registry.

c. The defendants may restructure or reorganize the current Appeals Unit or its successor administrative unit to facilitate the prompt, fair and efficient resolution of TennCare appeals; provided, however, that such administrative changes shall not impair compliance with this order.

i. The defendants will establish a new appeal resolution process which will be accessible through a toll-free phone number to TennCare enrollees on a 24 hour a day, 7 days a week basis to assist in the informal resolution of appeals (however, outside of regular business hours, only resolution of emergency appeals will be available).

ii. The defendants shall ensure that all TennCare enrollee appeals received by them are forwarded to the administrative unit responsible for processing appeals, and that they are processed in accordance with the terms of this order. All such appeals shall be immediately logged in the central registry.

d. The defendants shall allow an enrollee no less than 30 days from receipt of written notice or, if no notice is provided, from the time the enrollee becomes aware of an adverse action, to appeal any adverse action affecting TennCare services.

e. Enrollees shall be entitled to a hearing before an administrative law judge that affords enrollees the rights to:

i. Representation at the hearing by anyone of their choice, including a lawyer;

ii. Review information and facts relied on for the decisions by the MCC and the TennCare Bureau before the hearing;

iii. Cross-examine adverse witnesses;

iv. Present evidence, including the right to compel attendance of witnesses at hearings;

v. Review and present information from their medical records;

vi. Present evidence at the hearing challenging the adverse decision by her or his MCC;

vii. Ask for an independent medical opinion;

viii. Continue or reinstate ongoing services pending a hearing decision as specified herein; and

ix. A written decision setting out the administrative judge's rulings on findings of fact and conclusions of law.

f. But for initial reconsideration by an MCC as permitted by this order, no person who is an employee, agent or representative of an MCC may participate in deciding the outcome of a TennCare appeal. No state official may participate in deciding the outcome of a beneficiary's appeal who was directly involved in the initial determination of the action in question.

g. Consistent with the Code of Judicial Conduct, administrative law judges shall assist *pro se* enrollees in developing the factual record; they shall have authority to order second medical opinions at no expense to the enrollee.

10. ***Prohibition of denial of appeal rights***. The defendants and others acting on their behalf are prohibited from denying such appeal rights on any grounds whatsoever, including, but not limited to, the following:

a. Failing or refusing to accept as a request for appeal either of the following oral communications:

i. Oral requests by the beneficiary, or on his behalf, for information about appeal rights. Upon receipt of such a request, the defendants shall elicit from the beneficiary information as to whether he is dissatisfied and wishes to have his inquiry treated as an appeal.

ii. Oral or written expressions by the beneficiary, or on his behalf, of dissatisfaction or disagreement with an adverse action that has been taken or is proposed.

b. Refusing to provide an appeal because the beneficiary lacks an order or prescription from a provider supporting the appeal;

c. Refusing to provide an appeal because the defendants or others acting on their behalf have agreed to cover a prescribed service in an amount that is less than the amount or duration sought by the beneficiary;

d. Refusing to provide an appeal because the defendants or others acting on their behalf have agreed to provide a covered service that is different from that sought by the beneficiary.

Example. A beneficiary seeks residential mental health treatment in a particular facility, because it offers treatment for his particular disorder. The BHO offers residential treatment, but in another facility that the beneficiary believes cannot adequately treat his condition. The beneficiary is entitled to appeal the BHO's action.

e. Refusing to provide an appeal because the beneficiary seeks to contest a delay or denial of care resulting from the MCC's failure or refusal to make a needed service available, due to the inadequacy of the contractor's provider network.

f. Refusing to provide an appeal because the class member seeks to contest a denial of his right under the TennCare waiver to choose his own primary care provider (PCP) from among a panel offered by the MCO, or seeks to contest a delay or denial of care resulting from the involuntary assignment of a PCP.

g. Refusing to provide an appeal because the class member seeks to contest or change his assignment to a particular MCO or BHO.

h. Refusing to provide an appeal because the class member seeks to contest denial of TennCare coverage for services already received, regardless of the cost or value of the services at issue.

i. Refusing in-person hearings, failing to inform beneficiaries that they have the right to such hearings, or implying that they must agree to the conduct of hearings by phone conference.

j. Refusing to provide an appeal because the class member seeks to contest a decision of the TennCare Partners program granting or withholding designation as severely and persistently mentally ill (SPMI) or severely emotionally disturbed (SED).

These provisions do not affect the right of the defendants to deny or dismiss a request for a hearing under the circumstances specified in 42 C.F.R. §431.223.

11. ***Parties to appeals limited to those permitted by federal regulation.*** The parties to a hearing before an ALJ under this order are limited to those permitted by federal regulations. The purpose of the hearing is to focus on the beneficiary's medical needs. The defendant state officials shall not permit their contractors to intervene or participate as parties in a

TennCare beneficiary's hearing; provided, however, that nothing shall prevent MCC employees from participating as witnesses in ALJ hearings. Nothing in this provision bars participation by an MCC in any informal resolution phase of the appeal process prior to a hearing before the ALJ.

12. ***Impartiality of appeal process***. The defendants shall not compromise the impartiality and integrity of the appeal process by:

a. Impairing, or threatening to impair, the independence or autonomy of individuals charged with handling or deciding appeals, in order to influence the outcome of appeals;

b. Refusing to enforce, or by aiding MCCs in refusing to comply with, decisions in favor of beneficiaries;

c. Requiring that beneficiaries bear the expense of purchasing hearing transcripts;

d. Encouraging or demanding the waiver of any rights protected by this order, or by discouraging beneficiaries from exercising any such right;

Example: A beneficiary receives notice of a hearing on her appeal, and requests a continuance in order to have additional time to retain counsel and prepare her case. The defendants must not condition, or argue to the ALJ that he should condition, the continuance upon a complete waiver of the time requirements imposed by this order. (However, any delay fairly attributable to the requested continuance may be considered in calculating compliance with such requirements, as provided in subsection C(16)(f), below.)

e. Taking from the impartial decisionmaker the authority to decide some or all aspects of a beneficiary's appeal;

Example: A beneficiary appeals an MCO's denial of coverage. The MCO has determined that the services at issue are not medically necessary and, in any event, are not covered by the TennCare contract. The impartial decisionmaker must decide both issues. The defendants may not assign the medical necessity issue to the impartial decisionmaker but remove the contract coverage issue for decision by another agency or person.

f. In the case of an administrative law judge, engaging in *ex parte* communications regarding the merits of beneficiary appeals with individuals responsible for processing or deciding such appeals;

g. Failing to train personnel who are responsible for the appeal process regarding their obligations, and beneficiaries' rights, under this order;

h. Otherwise attempting to influence the outcome of the appeal process; provided, however, that the TennCare Bureau may participate as a defendant or respondent in beneficiary appeals before administrative law judges, and in subsequent judicial review proceedings.

13. ***When the beneficiary prevails***. If the enrollee prevails at any stage of the appeal process, the decision is binding upon the defendants and their contractors. If the enrollee prevails by decision of an administrative law judge (ALJ), the services shall be provided, and the defendants shall not appeal. An ALJ's decision in an enrollee's appeal shall not be deemed precedent for future appeals. The defendants may apply to this Court for relief from an ALJ's ruling interpreting federal law. The defendants may also enact emergency rules or public necessity rules in accordance with the state Administrative Procedures Act.

14. ***Special provisions relating to pharmacy services***.

a. When a provider with prescribing authority, as defined in paragraph B (15), prescribes a medication for a beneficiary, and the prescription is presented at a pharmacy that participates in the beneficiary's MCC, the beneficiary is entitled to either:

i. The drug as prescribed, if the drug is on the managed care contractor's formulary and does not require prior authorization; or

ii. The drug as prescribed, if the prescribing provider has obtained prior authorization or established the medical necessity of the medication; or

iii. An alternative medication, if the pharmacist consults the prescribing provider when the beneficiary presents the prescription to be filled, and the provider prescribes the substituted drug, or

iv. A two week supply of the prescribed drug, if the pharmacist is unable, when the beneficiary presents the prescription to be filled, to obtain either MCC authorization to fill the prescription as written or the prescribing provider's authorization to substitute an alternative medication. If the beneficiary does not receive the medication of the type and amount prescribed, the defendants or their contractors shall immediately provide written notice of the right to appeal, including the right to request continuation of services pending appeal, as required by this order. The enrollee's entitlement to receive a two week supply of the prescribed drug is subject to the provisions of subparagraph (b), below.

Example: A beneficiary receives a prescription from his TennCare primary care provider (PCP) or a specialist to whom the PCP has referred him. The MCO requires that clinicians obtain its prior approval before prescribing the drug in question, but the beneficiary's prescribing doctor failed to do so. The beneficiary must not be penalized for a failure on the part of his MCO or its contracting providers. If the beneficiary takes a prescription to a drugstore that is a member of the MCO's provider network, and the pharmacist is unable to either obtain authorization to fill the prescription or substitute another medication, the beneficiary is entitled to immediately receive a two week supply of the prescribed drug. The MCO may then initiate the reduction, termination or suspension process in accordance with this order in order to cut-off the medication.

b. The enrollee is entitled to a two-week supply of the prescribed drug, as mandated by the preceding subparagraph, provided that:

i. The medication is not classified by the FDA as less than effective (i.e., a DESI, LTE or IRS drug); or

ii. The medication is not a drug in a non-covered TennCare therapeutic category (e.g., appetite suppressants, drugs to treat infertility); or

iii. Use of the medication has not been determined, in accordance with subsection (C)(18) of this order, to be medically contraindicated because of the patient's medical condition or possible adverse drug interaction;

iv. If the prescription is for a total quantity less than a two week supply, the pharmacist must provide a supply up to the amount prescribed.

c. In some circumstances it is not feasible for the pharmacist to dispense a two week supply because the drug is packaged by the manufacturer to be sold as the original unit or because the usual and customary pharmacy practice would be to dispense the drug in the original packaging. Examples would include, but not be limited to, inhalers, eye drops, ear drops, injections, topicals (creams, ointments, sprays), drugs packaged in special dispensers (birth control pills; steroid dose packs), and drugs that require reconstitution before dispensing (antibiotic powder for oral suspension). When a coverage of a two week supply of a prescription would otherwise be required and when, as described above, it is not feasible for the pharmacist to dispense a two week supply, it shall be the responsibility of the MCC to provide coverage for either the two week supply or the usual dispensing amount, whichever is greater.

d. If the enrollee does not receive the medication of the type and amount prescribed, the defendants or their contractors shall immediately provide written notice of the right to appeal, including the right to request continuation of services pending appeal, as required by this order.

15. ***Special provisions relating to children in state custody.*** The defendants shall afford children in state custody the rights and protections established by 42 C.F.R. Part 431, Subpart E and the terms of this order. These children shall also receive the following enhanced protections:

a. As provided in the implementation plan referred to in subparagraph (e), below, whenever there is an adverse action affecting TennCare services (regardless of which contractor or government agency is administering such services), timely notices required by this order are to be sent to the individuals specified in the implementation plan. In the case of services administered by MCCs other than DCS, the responsible MCC shall provide notice to DCS, which shall ensure that timely notice is provided to the individuals listed herein. Delivery of notice triggering the right to appeal is not complete until notice is received by those individuals.

b. The defendants shall accept an appeal from any individual listed above as an appeal on behalf of the child;

c. The defendants shall maintain a contract with an entity that is mutually acceptable to the parties, to assist children in exercising the rights created by this order.

d. The defendants shall maintain a contract for the provision of free legal representation for such children, as necessary to enable them to effectively exercise their appeal rights under this order.

e. On January 5, 2000, the state defendants submitted a plan and implementation timetable governing compliance with this order as it affects children in state custody. The Court has approved that plan by order entered on January 14, 2000. (Docket entry 539)

16. ***Timely prior approval and resolution of appeals.***

a. Subject to the provisions of subparagraphs (h) and (i), below, the failure of an MCC to act upon a request for prior approval within 21 days shall result in automatic authorization of the requested service.

b. The defendants shall ensure that their managed care contractors complete reconsideration of beneficiary appeals within 14 days of notification by the defendants, in the case of a standard appeal, or within 5 days in the case of expedited appeals involving time-sensitive care. If an MCC fails to complete reconsideration of an appeal within the required time, the defendants shall immediately resolve the appeal in favor of the beneficiary, without further consideration or proceedings, subject to the provisions of subparagraphs (h) and (i) below.

c. Except upon a demonstration by the MCC of good cause requiring a longer period of time, the defendants shall ensure that within five (5) days of a decision in favor of the enrollee at any stage of the appeal process, the MCC completes corrective action to implement the decision, as described in subsection (d), immediately below.

d. For purposes of meeting the preceding time limit for corrective action, the defendants shall ensure that, whenever an appeal is resolved in favor of the beneficiary:

   i. The beneficiary actually receives the service at issue, or accepts and receives alternative services; or

   ii. If the beneficiary has already received the service at her own cost, the beneficiary has been reimbursed for her cost; or

   iii. If the beneficiary has already received the service, but has not paid the provider, the defendants have ensured that the beneficiary is not billed for the service and ensured that the beneficiary's care is not jeopardized by non-payment.

e. An appeal is not resolved by a decision adverse to the beneficiary until notice of the decision has been mailed to the beneficiary.

f. The defendants shall ensure that all standard appeals, including, if not previously resolved in favor of the enrollee, a hearing before an ALJ, are resolved within 90 calendar days of the defendants' receipt of the enrollee's request for an appeal. In cases involving time-sensitive care, the defendants shall ensure that expedited appeals, including, if not previously resolved in favor of an enrollee, a hearing before an ALJ, are resolved within 31 calendar days of the defendants' receipt of the request for an approval. Calculation of the 90 day or 31 day deadline may be adjusted so that the defendants are not charged with any delays attributable to the beneficiary. However, no delay may be attributed to a beneficiary's request for a continuance of the hearing, if she received less than three week's notice of the hearing, in the case of a standard appeal, or less than one week's notice, in the case of an expedited appeal. A beneficiary may only be charged with the amount of delay occasioned by her acts or omissions, and any other delays shall be deemed to be the responsibility of the defendants.

Example: A beneficiary receives one week's notice of his expedited appeal hearing but requests an additional week to obtain counsel and prepare his case. The hearing is continued a month. Only one week of the delay is attributable to the beneficiary.

g. Failure to meet the 90 day or 31 day deadline, as applicable, shall result in automatic TennCare coverage of the services at issue pending a decision by the ALJ, subject to the provisions of section (C)(18) relating to medical contraindication and subject to the provisions of subparagraphs (h) and (i), below. This conditional authorization will neither moot the pending appeal nor be evidence of the enrollee's satisfaction of the

criteria for disposing of the case, but is simply a compliance mechanism for disposing of appeals within the time frames established by this order. In the event that the appeal is ultimately decided against the beneficiary, she shall not be liable for the cost of services provided past the deadline for resolution of the appeal.

h. When, under the provisions of subparagraphs (a) or (b), above, a failure to comply with the timeliness provisions of this order would require the immediate provision of a disputed service, the defendants may, upon written notification of plaintiffs' counsel, decline to provide the service pending a contrary order on appeal, based upon a determination that the disputed service is not a TennCare-covered service. A determination that a disputed service is not a TennCare-covered service may only be made with regard to a service that:

   i. is subject to an exclusion that has been reviewed and approved by the federal Health Care Financing Administration and incorporated into a properly promulgated state regulation: OR

   ii. which, under Title XIX of the Social Security Act, is never federally reimburseable in any Medicaid program

Such a determination may not be based upon a finding that the service is not medically necessary.

i. In the event that the beneficiary lacks a prescription for a covered TennCare service, the defendants shall:

   i. Immediately afford the beneficiary access, at the earliest time practicable, to a qualified provider to determine whether the service should be prescribed; and

   ii. Inform said provider that the service will be authorized if prescribed.

Entitlement to said service will not be controlled by the contractor's utilization review process.

17. ***Specific prohibitions pertaining to timely decisions***. The defendants are prohibited from denying members of the plaintiff class timely resolution of their appeals for any reason or by any means. Delays which shall be deemed a violation of this prohibition specifically include, but are not limited to, those which result from:

    a. Affording the defendants' contractors an automatic period of 30 days from a decision favorable to the enrollee within which to cover the ordered services;

    b. Requiring enrollees who request a hearing before an administrative law judge to waive the 90 day or 31 day deadline, as applicable, altogether as a condition of obtaining an opportunity to prepare for the hearing;

    c. Treating cases which involve denials of coverage for services already received (sometimes referred to as "reimbursement appeals" and involving cases in which an enrollee has paid for services out of pocket or is being billed for services) as exempt from the 90-day time frame;

    d. Failing to inform enrollees of their right to receive disputed services, as provided in this order pending a decision on their appeal, when such appeals have not been decided by the ninetieth day following receipt of the request for a standard appeal, or thirty-first day, in the case of an expedited appeal.

18. ***Medical contraindication***. Whenever the terms of this order require the provision of TennCare benefits to an enrollee, the defendants and their contractors shall be relieved of such obligation upon compliance with this section. The defendants must provide the written certification of an appropriately licensed provider who is familiar with the beneficiary's medical condition. The provider must either be employed by the state or, if a licensed

pharmacist determining contraindication with regard to a prescribed drug, must be making such determination consistent with pre-established standards and procedures approved by the state. The certification must document that the service in question is medically contraindicated, making it necessary to withhold the service in order to safeguard the health or safety of the beneficiary. In such cases, the defendants must immediately:

a. Provide written notice to the beneficiary, and the notice must be accompanied by the provider's certification that the service must be withheld in order to protect the beneficiary's health or safety; and

b. Forward a copy of the beneficiary notice and provider certification to counsel for the plaintiff class. In the case of pharmacists' determinations of contraindication, the defendants shall forward to plaintiffs' counsel monthly drug utilization review reports from the MCCs or their PBM subcontractors, documenting the application of the contraindication provision during the preceding month.

Attached as part of Collective Exhibit B to this order is a sample notice that satisfies the requirements of this provision, and that shall be used by the defendants as a template for the notices they issue.

19. ***Accommodation of persons with disabilities***. The defendants and others acting on their behalf shall provide reasonable accommodation to class members with disabilities who require assistance in order to exercise the rights afforded by this order, including the right to appropriate notice. To obtain technical assistance in designing and implementing policies and training to effect compliance with this requirement, the defendants shall contract by no later than thirty days from the date of entry of this order with an organization(s) which has expertise in accommodating the needs of people with the range of disabilities reflected in the plaintiff class. The defendants shall not reduce or terminate current contractual

arrangements with private entities that assist TennCare beneficiaries through the appeal process without the agreement of the plaintiffs or prior approval of the Court, based upon a showing that such changes will not impair access to the appeal process for people with disabilities.

20. ***Training and public notice requirements.***

    a. Within seven days of the entry of this order, the defendant state officials shall issue appropriate notices to their contractors, within thirty days to TennCare providers and to TennCare beneficiaries within sixty days informing them of the rights and responsibilities established by this order.

    b. The defendant state officials shall implement a training program for state personnel and MCCs to ensure that individuals whose job responsibilities are affected by this order are promptly informed of the order's terms. The defendants shall ensure that responsible state and MCC staff receive training as needed on an ongoing basis to maintain their awareness of, and compliance with, the terms of this order.

    c. The defendants shall ensure that notices of the right to appeal adverse decisions affecting services are conspicuously displayed in public areas of all providers participating in each MCC, of MCC facilities, of county health departments, and of county Department of Human Services offices.

21. ***Defendants' enforcement responsibilities.*** The defendant state officials shall promptly and faithfully enforce against their contractors any appeal decision rendered in favor of a beneficiary.

    a. If the beneficiary went without coverage of the disputed services while the appeal was pending:

i. The defendants shall promptly reimburse the beneficiary for any costs incurred for obtaining the services at the beneficiary's expense; and

ii. As to the MCC which wrongfully withheld the services, the defendants shall assess an amount sufficient to at least offset any savings the contractor achieved by withholding the services.

b. The defendant state officials shall analyze beneficiary appeals and monitor MCC appeal procedures on an ongoing basis for the purpose of identifying patterns that reflect systemic problems or violations of the law. The defendants shall take prompt corrective action, including the imposition of sanctions, when such patterns are identified. For purposes of this requirement, a systemic violation by an MCC includes, but is not limited to, a failure in 20% or more of appealed cases over a 60-day period to satisfy all of the notice requirements imposed by this order.

c. Without regard to whether a single violation is part of a systemic pattern of noncompliance and punishable as such, the defendants must impose individual sanctions on their contractor for each instance known to them in which the contractor violates this order by:

i. Failing to provide written notice of adverse action to a beneficiary as required by this order;

ii. Failing to forward a beneficiary's appeal to the defendants;

iii. Failing to provide continuation or restoration of services pending appeal when requested to do so;

iv. Failing to take timely corrective action to implement an appeal decision in a beneficiary's favor.

For each such violation occurring after September 15, 2000, the defendants shall impose a liquidated penalty of no less than $250. For each such violation occurring after October 15, 2000, the defendants shall impose a liquidated penalty of no less than $500. In addition to such liquidated penalty, the defendants shall levy a monetary sanction in an amount sufficient to at least offset any savings the contractor achieved by withholding the service at issue.

D. Monitoring, Reports and Disclosures

1. The defendants shall continue to have primary responsibility for monitoring and enforcing compliance with this order and the regulations and laws incorporated herein. In addition, the defendants will enter into an agreement with the Tennessee Comptroller of the Treasury to monitor all aspects of compliance with this order, by any state agency or contractor subject to its terms. Under that agreement, the Comptroller is to have access to any and all records, documents or personnel needed to ascertain compliance, and shall employ all methods normally used to audit and evaluate compliance with financial and legal standards.
2. The Comptroller will submit quarterly reports to the defendants, who shall immediately file copies of the same with the court and provide copies thereof to counsel for the other parties to this case. The quarterly reports, the first of which is to be filed no later than 120 days after the date of entry of this Order, shall report on compliance with the terms of this order. The reports will address specifically, but not exclusively, the following areas:
   a. Compliance with notice and appeal procedures when the defendants or others acting on their behalf propose to take any adverse action affecting inpatient or residential behavioral health services.
   b. Compliance with requirements that provide special notice and appeal protections for children in state custody.

c. The consistency and rigor of the defendant state officials' actions to enforce the terms of this order against their contractors.

d. The extent to which the defendant state officials are analyzing data to identify patterns of contractor non-compliance with federal or state requirements and taking appropriate action to correct systemic violations or other problems adversely affecting beneficiary care.

e. Compliance with the special provisions pertaining to pharmacy services.

f. The adequacy of beneficiary notices provided by state officials and their contractors.

g. Compliance with requirements for the public posting of notices informing beneficiaries of the rights and protections incorporated in this order.

3. The defendants shall promptly provide to plaintiffs' counsel copies of all reports which they generate or receive pertaining to the TennCare appeal process or to compliance with any aspect of this order. These reports shall include, but are not limited to, monthly reports compiled from the appeal central registry indicating

a. The number of appeals by MCC, the type of care;

b. The number of days for resolution of the appeal;

c. Type of resolution (i.e., reversal or affirmance after reassessment by MCO or BHO; reversal or affirmance after review by TennCare or TennCare Partners; reversal or affirmance after hearing);

d. The amount of sanction imposed in each case where the MCC's action is reversed after review by TennCare or TennCare Partners, or after hearing; and

e. Listing sanctions actually collected during the month.

The defendants shall forward to plaintiffs' counsel within 30 days of the entry of this order all monthly appeal central registry reports that have been compiled since the entry of the August 27, 1996 consent decree but not previously submitted to plaintiffs' counsel.

4. The defendants shall provide plaintiffs' counsel, at least 30 days prior to their adoption and dissemination, copies of all sample beneficiary communications including form notices required under this order, policy memoranda, training materials, Comptroller's audit tools and protocols, proposed and final rules, or proposed waiver revisions or clarifications affecting any aspect of compliance with this order. The defendants shall promptly provide the plaintiffs' counsel copies of correspondence relating to the imposition of sanctions on an MCC for any systemic violation of this order. The defendants shall provide the plaintiffs copies of any proposed contract amendments affecting compliance with, or implementation of this order, at least ten days in advance of the execution of said amendments.

4. Upon ten (10) days prior written notice, the defendant state officials shall provide plaintiffs' counsel access to any documents or records under their control, or under the control of their contractors, which plaintiffs' counsel request to inspect for purposes of monitoring compliance with this order. The defendants shall not assert any privilege, other than attorney-client privilege, with regard to any document or other evidence requested by plaintiffs' counsel and pertaining to any matters covered by this order. Plaintiffs' counsel shall maintain the confidentiality of class members' TennCare and medical records. Any proprietary information shall be subject to a protective order, which the parties shall draft and submit to the Court.

E. Attorneys' Fees

The plaintiffs are prevailing parties for purposes of their entitlement to an award of attorneys' fees under 42 U.S.C. §1988 for legal services rendered by their counsel in connection

with these proceedings. By order entered June 28, 2000, the Court has awarded fees for services rendered through October 26, 1999.

F. Effective Dates

Except as otherwise explicitly provided herein, those provisions of this order which have not already taken effect under the terms of previous orders shall take effect on August 1, 2000.

G. Relief for Individual Class Members

Under the terms of the Revised Consent Decree Governing TennCare Appeals, the defendants were ordered, effective October 26, 1999, to take immediate corrective action as necessary to ensure that Sarah Cornett and Mathew Cole receive medically necessary behavioral health service. The defendants were also ordered to immediately apply subsections C(8), C(10)(b)–(j), C(11), C(12), C(13), C(16)(a), C(16)(b), C(16)(d)(i), C(16)(e), C(16)(f), and C(16)(g) to any class member whose appeal was currently pending at any stage of appeal or judicial review. The defendants were directed to immediately apply the terms of this order to any individual who had obtained a favorable decision on appeal and had such decision reversed by the defendant Commissioner of Health or her designee; the defendants was ordered to ensure that the decisions favorable to those class members were immediately reassessed and appropriate corrective action taken, if necessary. These provisions all remain in full force and effect; provided, however, that, as to administrative appeals which were pending on October 26, 1999, and to which MCCs had already been admitted as parties, the requirements of subsection (C)(11) shall be indefinitely suspended, contingent upon the administrative appeals being stayed and the beneficiaries receiving the services pending appeal.

H. Class Action Provisions

Upon entry of the Revised Consent Decree Governing TennCare Appeals, the Court, pursuant to Rule 23, subdivisions (c) - (e), of the Federal Rules of Civil Procedure, amended the

definition of the plaintiff class herein by revising the definition of the plaintiff class to prospectively include all present and future enrollees in the TennCare program. The class thus redefined shall be bound by the terms of this order. The Court determines that the notice provisions set forth above are sufficient to fairly notify class members of the terms of this order.

I. Exclusions and Reservations

1. As they take effect, the provisions of this order shall supersede those provisions of the Second Consent Decree (Docket Entry 278) and the Agreed Order of August 27, 1996 (Docket Entry 387) which address procedural due process for beneficiaries when medical assistance is delayed, denied, reduced, suspended or terminated. The remaining provisions of the Second Consent Decree dealing with transportation and limitations on participating providers' ability to bill enrollees remain in full effect and are unaffected by this order; provided, however, that those provisions do not limit the ability of the defendants or their contractors to collect co-payments or deductibles when authorized to do so by the terms of the TennCare waiver. This order is designed to correct problems with the interpretation and application of the two previous orders, to better protect members of the plaintiff class and strengthen the procedural due process protections available to them.

2. Nothing herein shall affect those terms in earlier orders, including specifically the agreed orders of July 25, 1989 (Docket Entry 264) and May 15, 1999 (Docket Entry 277), which address transportation services or the redetermination of Medicaid eligibility for members of the plaintiff class.

3. This order shall not affect the right of any individual class member to seek any and all relief that is otherwise available through administrative review proceedings against the state before the Tennessee Claims Commission based upon alleged actions or omissions of the state defendants, or through litigation authorized by other state or federal law. It is intended

to adjudicate with respect to the class and its individual members only those claims for relief which were made on their behalf in the motion for contempt, and to thus bar further proceedings by class members seeking the same relief under 42 USC § 1983. The parties acknowledge the state may assert any and all defenses available in any such administrative, Claims Commission or other litigation.

4. The plaintiffs will not initiate contempt proceedings to enforce the terms of this order without having first made a good faith effort to apprise the defendants of any concerns regarding noncompliance.

5. The plaintiffs' motions for contempt and for preliminary injunctive relief were withdrawn on October 26, 1999, upon entry of the Revised Consent Decree Governing TennCare Appeals.

IT IS SO ORDERED.

Senior United States District Judge